Putting the Mouth Back in the Body: Collaborating for Oral Health Integration

Collaborating for Health

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Advancing Healthcare
Improving Health

Objectives

- Explain the case for change: Why oral health makes sense as a part of Primary Care

- Present the Oral Health Delivery Framework: A definition what can be done in Primary Care

- Describe a project to streamline fitting oral health into the Primary Care workflow including referrals

- Share population management tools we developed for the project

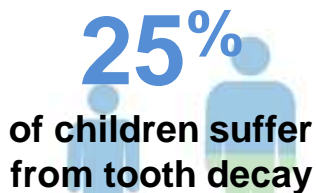- Review "key learnings" from this work

What is the problem we are trying to solve? *A Prevention Gap*

- Caries and periodontal disease are preventable chronic infectious diseases

- Unacceptably high burden of disease nationwide

- Dental care is the most common unmet health need

- The healthcare system, as currently configured, fails to reach the populations with the highest burden of disease resulting in pervasive health disparities and wasteful spending
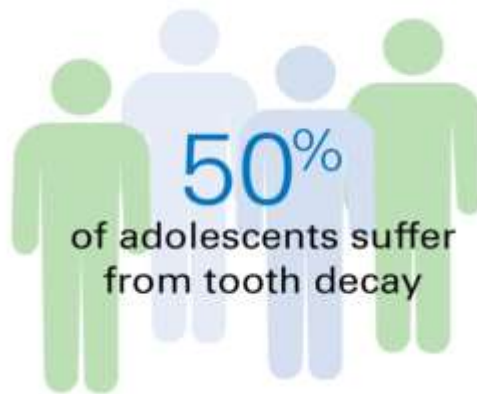
We need an *upstream* solution…
a way to intervene *earlier* in the course of disease

25%
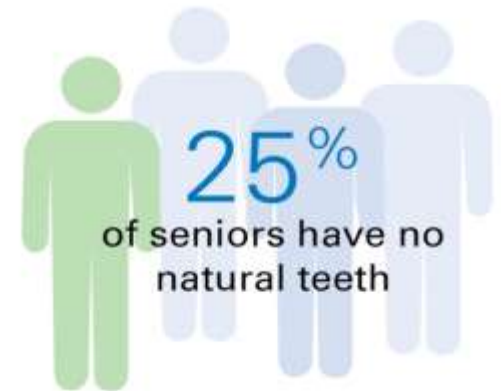**of children suffer from tooth decay**

50% of adolescents suffer from tooth decay

25% of seniors have no natural teeth

The proposal?
Expand the oral disease prevention workforce by engaging primary care teams in the fight against oral disease

Why enlist primary care teams?

Population Receiving Regular Medical Care

Total Population at Risk for Caries and Periodontal Disease

Population Receiving Regular Dental Care

Access:

Frequent contact with high-risk groups:

Children, pregnant women, adults with diabetes
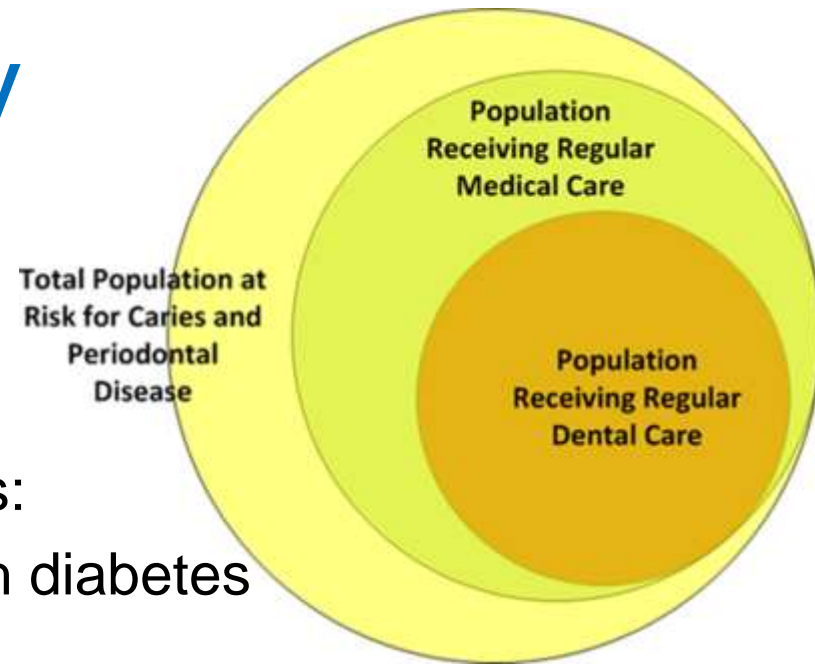
Skills:

- Disease prevention
- Risk assessment, screening, case-finding
- Help patients navigate the healthcare system
- Engage patients in behavior change

A natural extension of what primary care teams already do…

- Educate patients about healthy behaviors to reduce risk
- Screen for disease and refer to specialists for definitive diagnosis and treatment
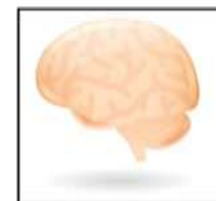
Why should the mouth be excluded?

- Common problem, serious consequences
- Early recognition and treatment to reduce impact
- Patient and family behavior (self-care) is key

Partnership for Prevention

Primary Care   Dental Care

Population Health Management and Reporting Tools*

Restorative Treatment of Caries

Quality Improvement Methodology

Care Coordination

Prevention

Medication List Management

Risk Assessment
Dietary Counseling
Oral Hygiene Training
Smoking Cessation
Fluoride Varnish
Fluoride Supplementation
Antibiotic Rinses
Screening for Oral Diseases

Dental X-rays
Dental Sealants
Periodic Cleaning
Mouth Guards

Endodontics

Orthodontics

Crowns and Implants

Management of Chronic Diseases

Deep Scaling and Root Planning for Periodontal Disease

*Including structured EHR data and diagnostic codes, disease registries, and other tools

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Care for Ms. G

- Ms. G is a 69 year-old woman suffering from diabetes, hypertension, and asthma.

- Her medical care is managed largely in a primary care clinic, which monitors her blood sugar and blood pressure every 3 months, and adjusts her medications accordingly.

- Her asthma severity is briefly assessed at each visit, and every autumn (before influenza season) her care team reviews her lung function, adjusts her medications if necessary, and makes sure she receives her flu shot.

- At a yearly visit, special attention is given to testing for kidney disease and loss of sensation in her feet. She is seen by an optometrist for an eye exam.

Care for Ms. G

- A year ago, her care team began screening for **oral disease** while assessing her eyes, feet, and kidney function.

- The initial oral health assessment showed moderate to severe periodontal disease and several root caries.

- The care team trained her in optimal oral hygiene and helped her identify ways she could reduce the sugar content in her diet.

- Her primary care provider also referred Ms. G to a dentist with a formal request to evaluate and manage her periodontal disease and root caries.

- The referral included a copy of Ms. G's problem list, medication list, and allergy list.

- The dentist returned a consultation note to the referring provider in which the dentist noted his impression, described the interventions taken, and outlined a care plan.

Oral Health in Primary Care

Sponsor: National *Interprofessional Initiative* on Oral Health — engaging clinitians, eradicating dental disease

Consultant: QUALIS HEALTH.

Funders: DentaQuest FOUNDATION

REACH healthcare foundation

Washington Dental Service Foundation

Community Advocates for Oral Health

About the Project

Goal: Prepare primary care teams to deliver preventive oral health care and improve referrals to dentistry.

- Reviewed literature and results of recent efforts to integrate behavioral health services

- Convened a Technical Expert Panel:

  – Primary care and dental providers

  – Leaders from medical, dental, and nursing associations

  – Payers and policymakers

  – Patient and family engagement experts

  – Public and oral health advocates

Question: What will it take to change the standard of care?

1. Clear definition of what can be done in the primary care setting to protect and promote oral health
2. Streamlined process for fitting oral health into an already packed primary care workflow
3. Practical model for a close collaboration between medicine and dentistry

Oral Health Delivery Framework

5 actions primary care teams can take to protect and promote their patients' oral health. Within the scope of practice for primary care; possible to implement in diverse practice settings.

ASK
about oral health risk factors and symptoms of oral disease

LOOK
for signs that indicate oral health risk or active oral disease

DECIDE
on the most appropriate response

ACT
offer preventive interventions and/or referral for treatment

DOCUMENT
as structured data for decision support and population management
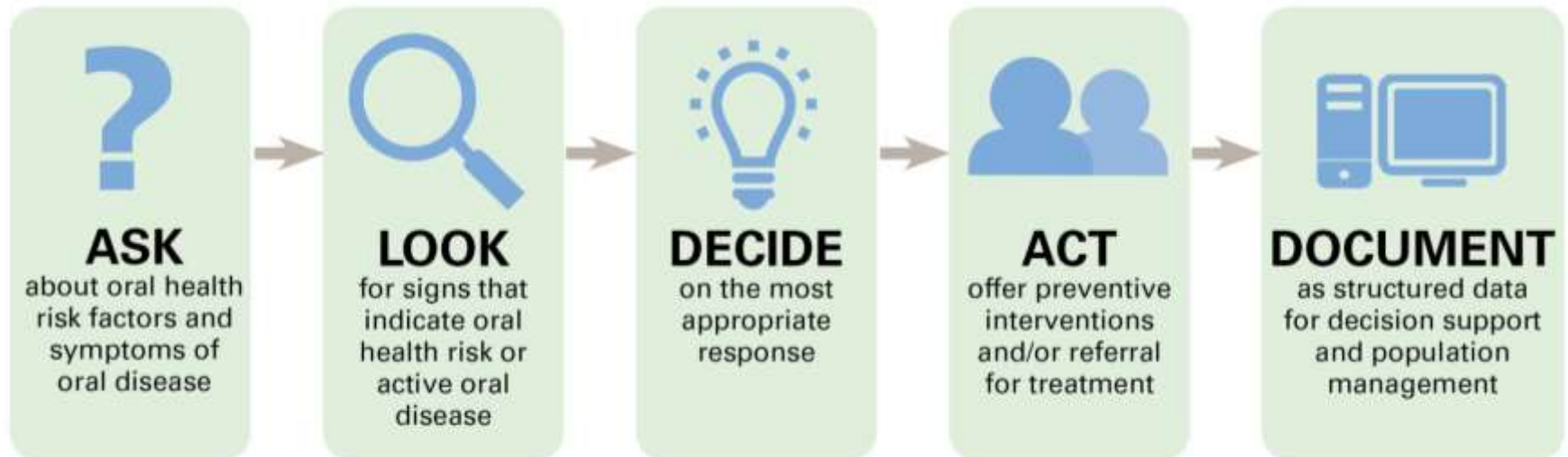
Preventive interventions: Fluoride therapy; dietary counseling to protect teeth and gums; oral hygiene training; therapy for substance use; medication changes to address dry mouth

Citation: Hummel J, Phillips KE, Holt B, Hayes C. *Oral Health: An Essential Component of Primary Care.* Seattle, WA: Qualis Health; June 2015

National *Interprofessional Initiative* on Oral Health

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Who will do this new work? *It depends*

- Size and structure of the practice
- Provider comfort with delegation
- Needs and preferences of patient population
- Visit type

There are many options.

Pt makes appointment to see care team → MA reviews charts of Pts on schedule & identifies those needing Oral Health Assessment → Team huddles to plan visit & finalize priorities for each patient → Front Desk verifies dental insurance & last time seen by dentist

MA rooms Pt: Asks OH screening questions & Looks the mouth for signs of disease, places and pends orders for provider to sign → Provider reviews information gathered by MA, makes decisions, gives advice, orders tests and treatments → Treatments, prescriptions, patient education, referrals → Pt leaves with referral

Structured Referrals

Primary Care Workflow: Referral to Dentistry

Report is entered in EHR

Clinical Assistant asks, looks, makes preliminary decision, pends referral order

Provider reviews completes & signs referral

Clinical Assistant reviews referral expectations

Referral Coordinator processes and sends referral

Pt leaves with referral

Dental Office Workflow: Referral from Primary Care

Dental office processes referral

Pt makes appointment

Pt has appointment with dentist

Dentist writes consultation report

Dental office sends consultation report to referring provider office

Info PCP to Dentist   From Dentist to PCP

- Service requested and reason for referral
- Additional relevant clinical data
  - Problem list (abbreviated to relevant issues)
  - Current med list
  - Allergy list
  - Relevant medical/surgical history
  - Pertinent labs and imaging

- Date patient seen
- <u>Impression</u>: What was found, e.g.,
  - Caries in multiple teeth
  - Periodontal disease: level severity
- <u>Disposition</u>: What was done
  - Procedures
  - Any meds prescribed
- Brief treatment & follow-up plan

Oral Health: An Essential Component of Primary Care

Published June 2015

- Case for change

- Oral Health Delivery Framework

- Supporting actions from stakeholders

- Case examples from early leaders: Confluence Health, The Child and Adolescent Clinic, Marshfield Clinic

Available at: www.QualisHealth.org/white-paper

Hummel J, Phillips KE, Holt B, Hayes C. *Oral Health: An Essential Component of Primary Care*. Seattle, WA: Qualis Health; June 2015
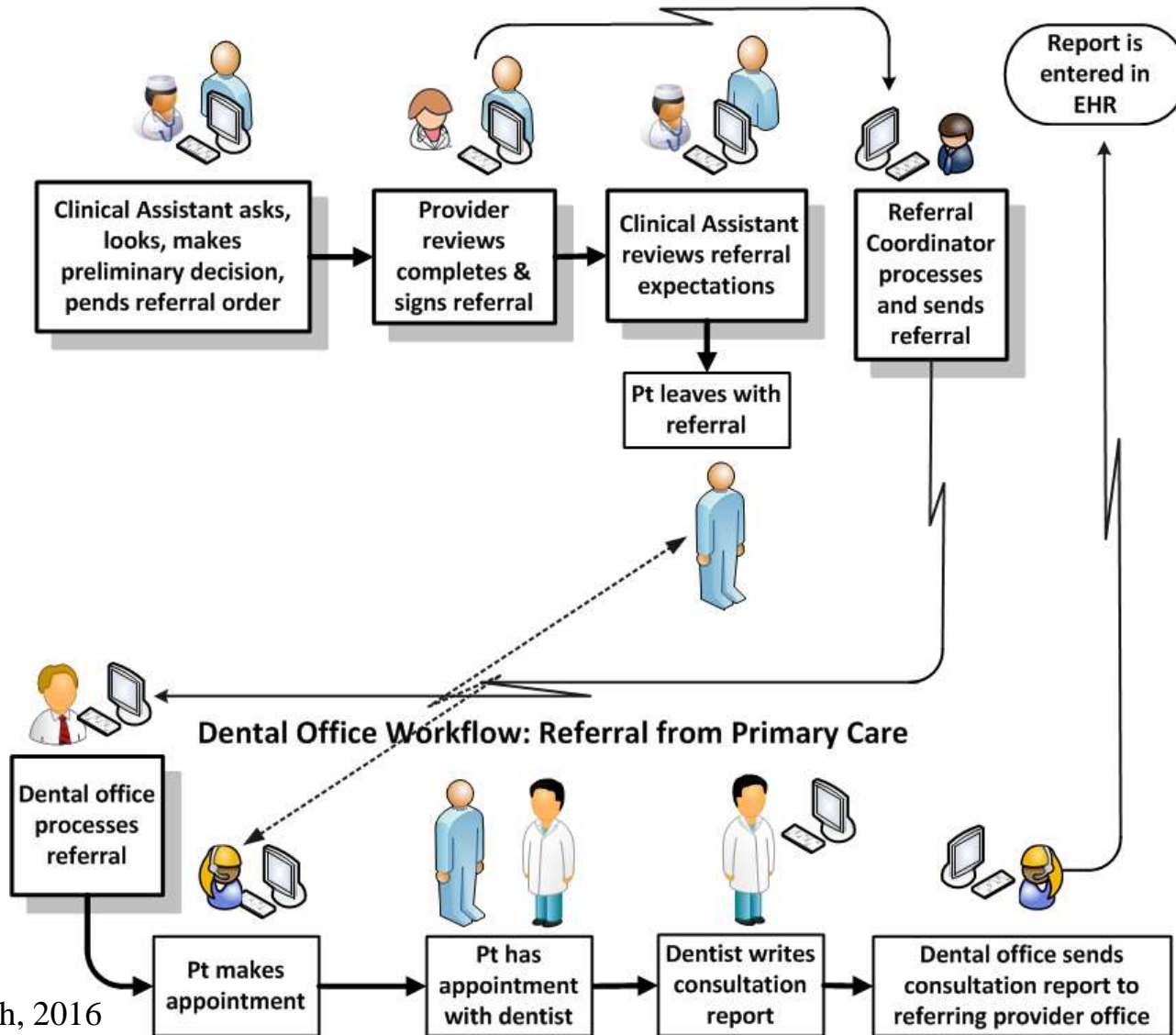
Endorsed by:

American Academy of Nursing
American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Colleges of Nursing
American Association for Community Dental Programs
American Association of Public Health Dentistry
American College of Nurse Midwives
American Public Health Association – Oral Health Section
Association of Clinicians for the Underserved
Association of Faculties of Pediatric Nurse Practitioners (AFPNP)
Association of Maternal & Child Health Programs
Association for State and Territorial Dental Directors
Institute for Patient- and Family-Centered Care
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Network for Oral Health Access
National Organization of Nurse Practitioner Faculties
National Rural Health Association
Physician Assistant Education Association
Patient-Centered Primary Care Collaborative
Supported by the American Academy of Family Physicians and the National Association of Community Health Centers

The Big Question: *Is it feasible?*

- Possible without new members of the team and within a small practice setting
- Most activities can be performed by a trained Medical Assistant or LPN; minimal impact on provider time
- Does not require specialized equipment or space
- Advanced primary care practices have resources in place to implement now; others can take an incremental approach:
  - ✓ Begin with risk assessment and risk reduction; or,
  - ✓ Screening and structured referral

Field-Testing a Conceptual Framework

Develop **Test** **Improve** **Disseminate**

19 diverse healthcare delivery organizations: Private practices, Federally Qualified Health Centers; medical only and on-site dental

Adults with diabetes (12), pediatrics (5), pregnancy (1), adult well visits (1)
eCW (5), EPIC (8), NextGen (2), Centricity (2), Success EHS (2)

Washington Dental Service Foundation
Community Advocates for Oral Health

R E A C H
healthcare foundation

DentaQuest FOUNDATION

Oregon Primary Care Assoc.
Kansas Assoc. Medically Underserved (*)
Massachusetts League of CHCs

*Support also provided by:
Kansas Health Foundation
United Methodist Health Ministry Fund

Technical Assistance
Qualis Health & State Primary Care Assoc.

- Assessment and goal setting

- Clinical content training

- Workflow mapping

- Development of a referral network (mix of private practice dentists and CHCs)

- HIT modification guidance

- Reporting

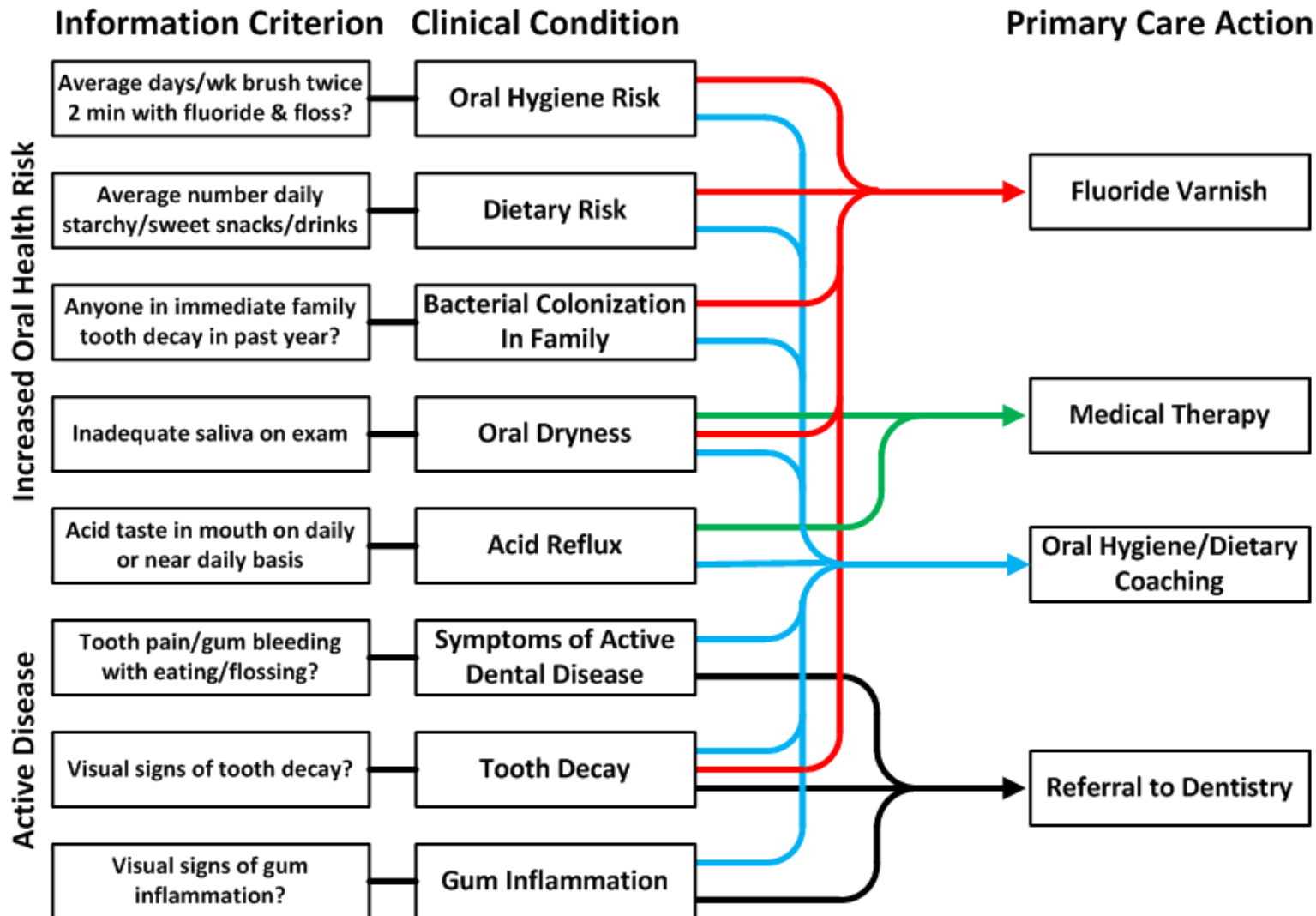- Planning for spread: New target populations, teams, sites

Assessment & Goal-Setting

- Assessment
  - Team resources
  - Health IT flexibility
- Goal-setting
  - Target Population
  - Standard of care
  - Pilot team
  - Spread strategy

Clinical Content Training
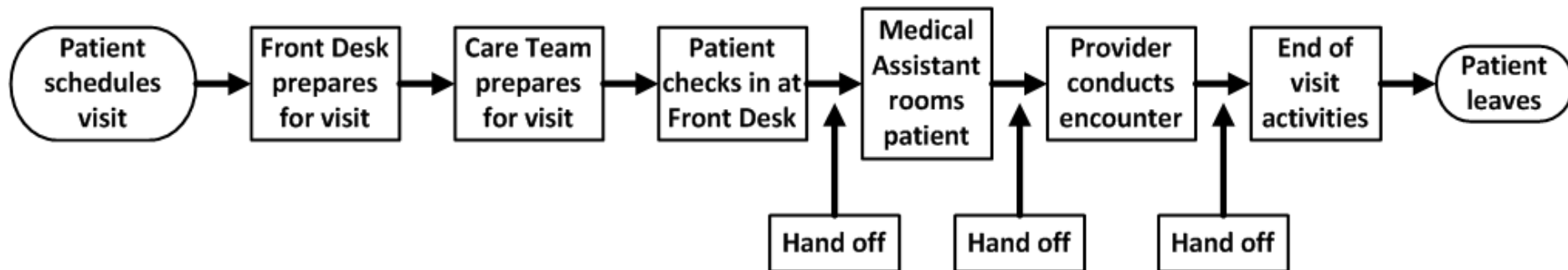
- Anatomy & Pathophysiology
  - <u>Saliva</u>: protective role; medication side effects
  - <u>Teeth</u>: demineralization balance; caries
  - <u>Gums</u>: spectrum of periodontal disease
- Target Population
  - Caries of childhood
  - Periodontal disease in adults with diabetes
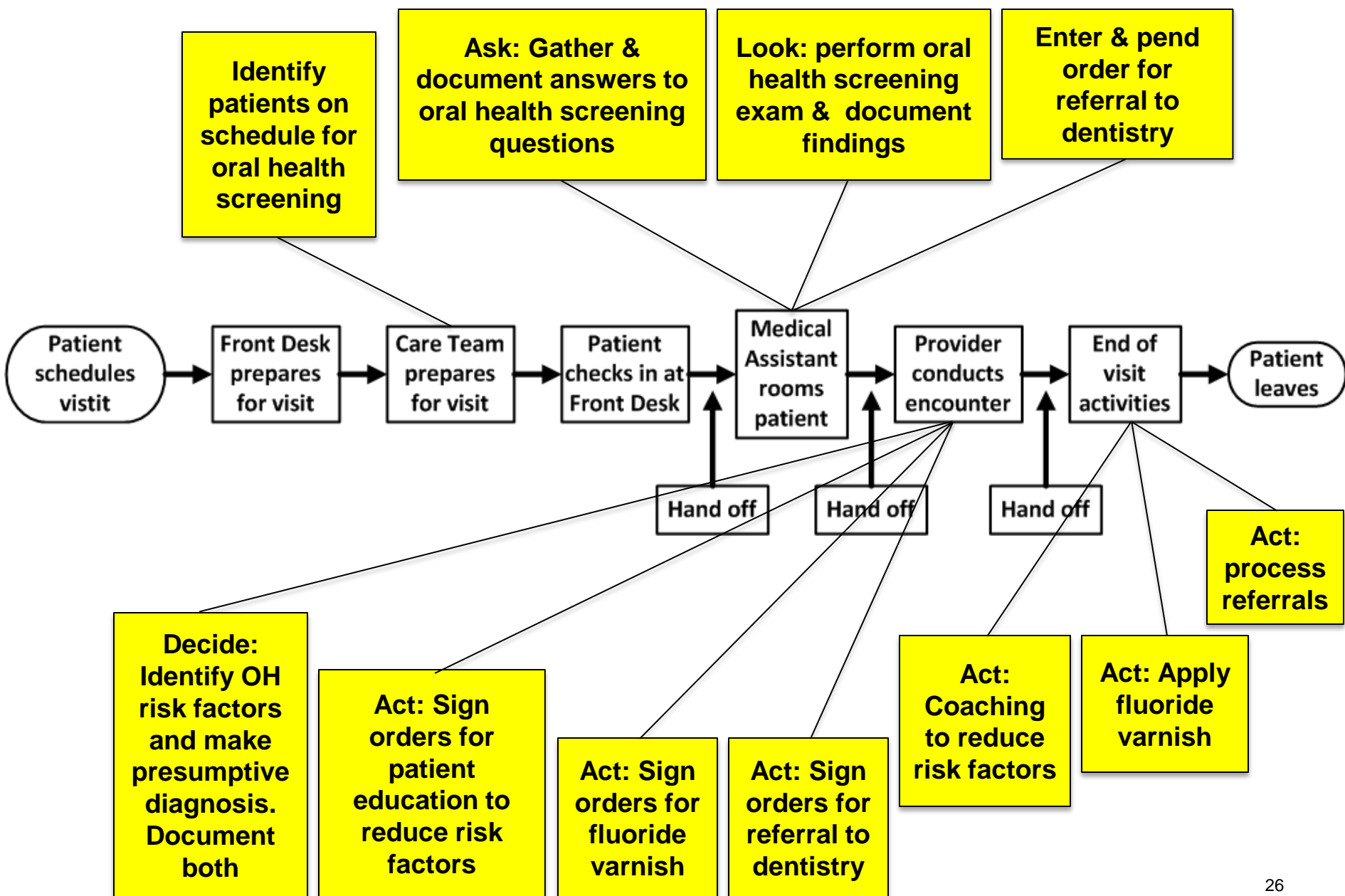 - Threats to oral health during pregnancy

An Algorithm Driven Intervention

Information Criterion   **Clinical Condition**   **Primary Care Action**

Increased Oral Health Risk

- Average days/wk brush twice 2 min with fluoride & floss? → Oral Hygiene Risk
- Average number daily starchy/sweet snacks/drinks → Dietary Risk
- Anyone in immediate family tooth decay in past year? → Bacterial Colonization In Family
- Inadequate saliva on exam → Oral Dryness
- Acid taste in mouth on daily or near daily basis → Acid Reflux

Active Disease

- Tooth pain/gum bleeding with eating/flossing? → Symptoms of Active Dental Disease
- Visual signs of tooth decay? → Tooth Decay
- Visual signs of gum inflammation? → Gum Inflammation

Primary Care Actions:
- Fluoride Varnish
- Medical Therapy
- Oral Hygiene/Dietary Coaching
- Referral to Dentistry

Workflow Optimization

- What do you want to do?
- Where should it be done?
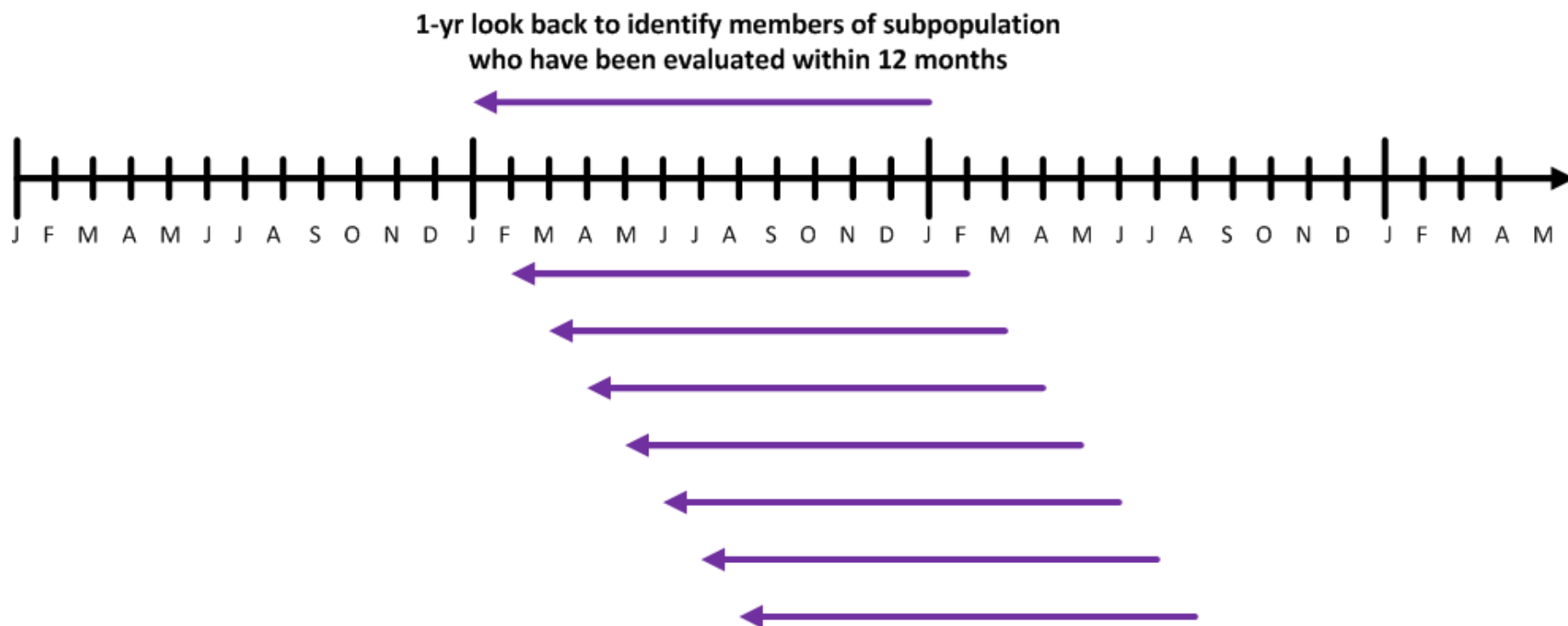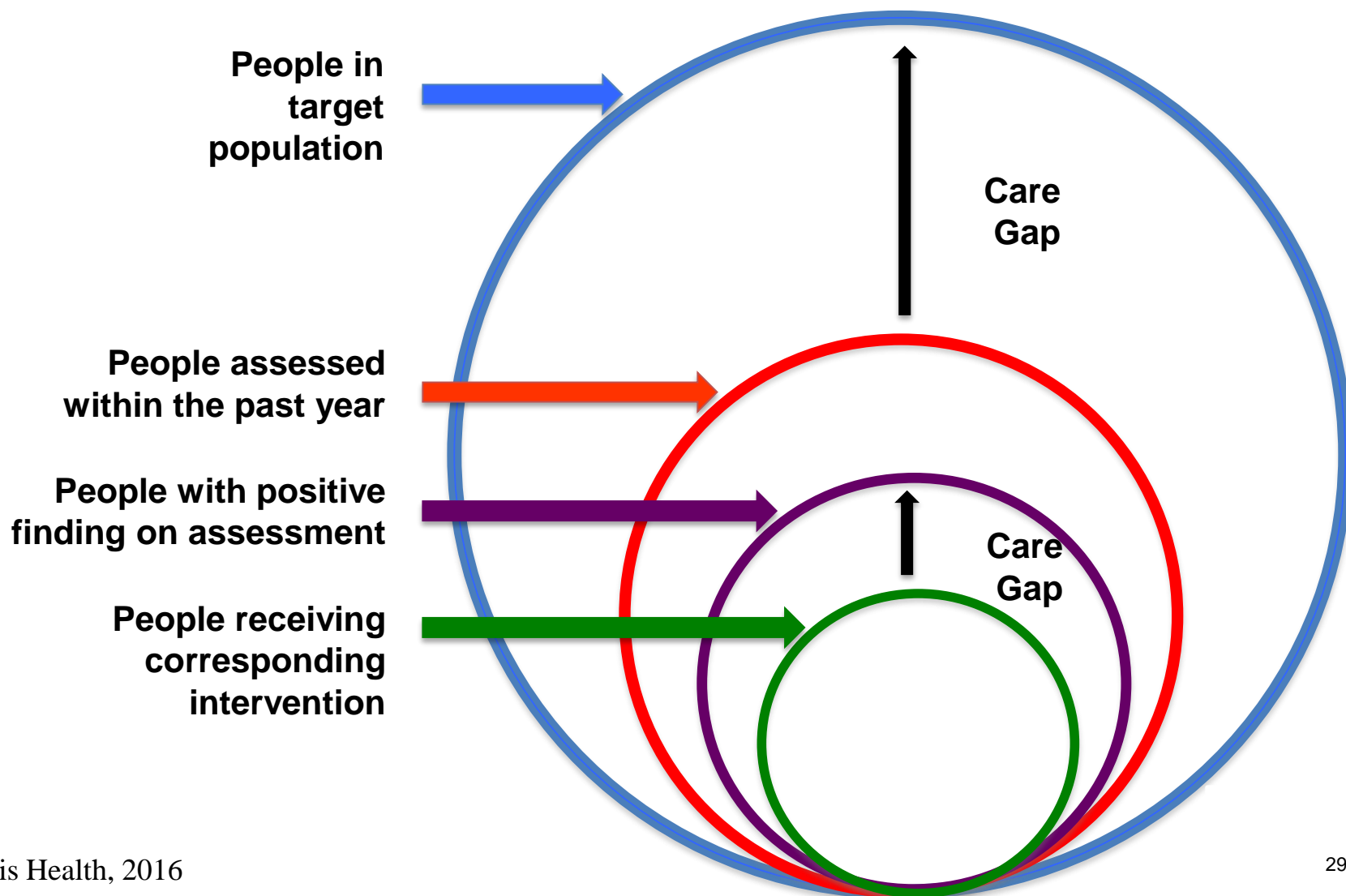- Who should do it?

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Measuring Population Process Outcomes

- Who is in the target population? (Now)
- Who have we screened? (In the past year)
- What did we find? (Risk factors; disease)
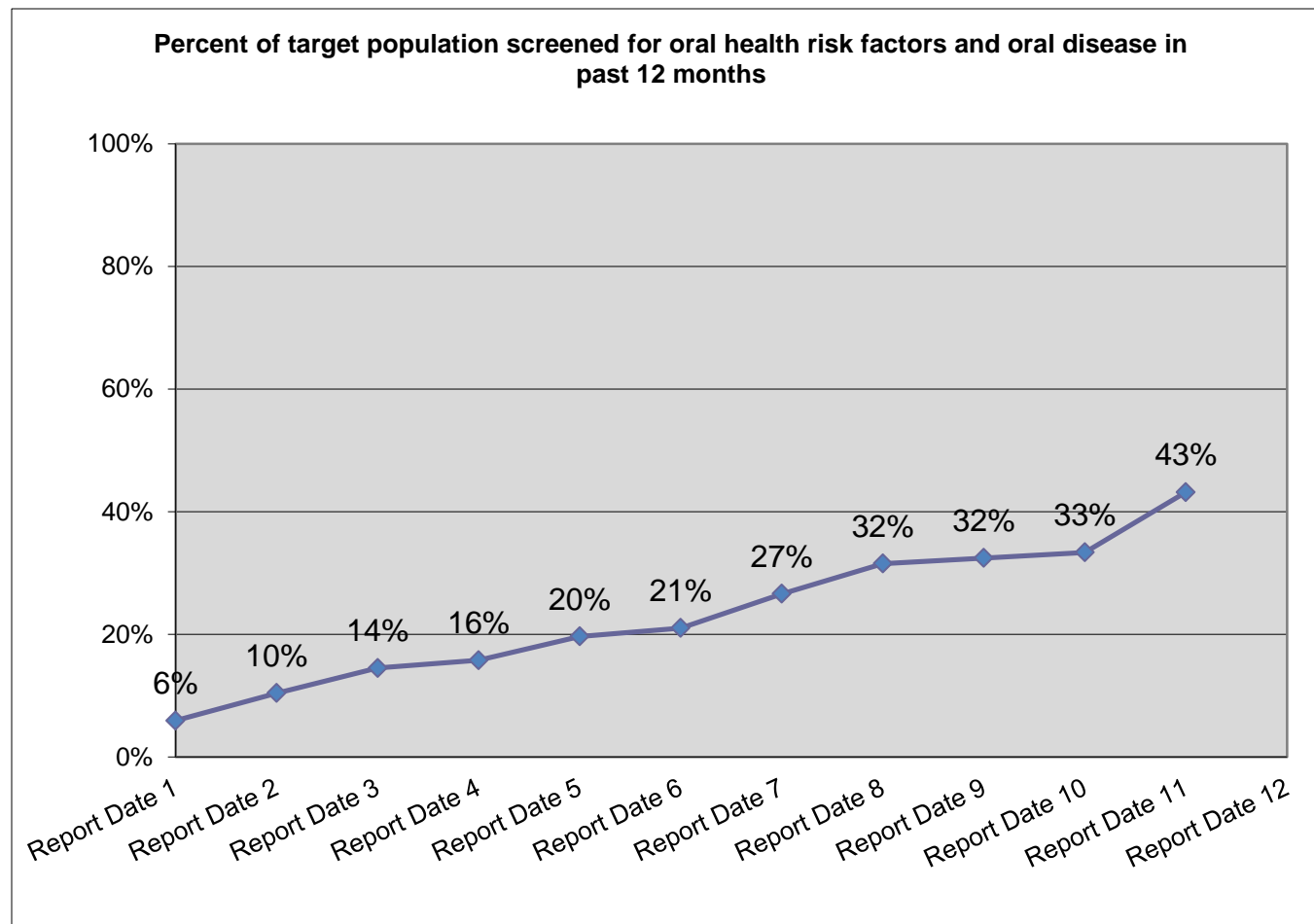- What did we do? (Algorithm adherence)

Constantly Changing Numerators and Denominators

1-yr look back to identify members of subpopulation who have been evaluated within 12 months

Population Oral Health

People in target population

People assessed within the past year

People with positive finding on assessment

People receiving corresponding intervention

Care Gap

Care Gap

Over Time Run Charts Tell the Story

Percent of target population screened for oral health risk factors and oral disease in past 12 months

- Report Date 1: 6%
- Report Date 2: 10%
- Report Date 3: 14%
- Report Date 4: 16%
- Report Date 5: 20%
- Report Date 6: 21%
- Report Date 7: 27%
- Report Date 8: 32%
- Report Date 9: 32%
- Report Date 10: 33%
- Report Date 11: 43%

Field-Testing Results: Future Tools

"Oral Health Integration Implementation guide"

Toolkit for primary care teams (Avail Oct 2016)

- Workflow maps
- Referral agreements
- Patient engagement strategies
- Patient/family education resources
- EHR templates
- Case examples
- Impact data and more

Case Study: SURHC

<u>Samuel U. Rodgers Health Center- Lexington Clinic</u>

- Began oral health integration pilot May 2015, starting in a small rural clinic in Lexington, MO.

- Primary pilot team- NP, Practice Manager, and a Dental Director (co-located dental clinic).

- Target Populations: Well Adult visits and Well Child Visits. Spread to Prenatal visits after several months

- Modified workflow, engaged in staff training via Smiles for Life, modified their EHR to integrate oral health assessment questions
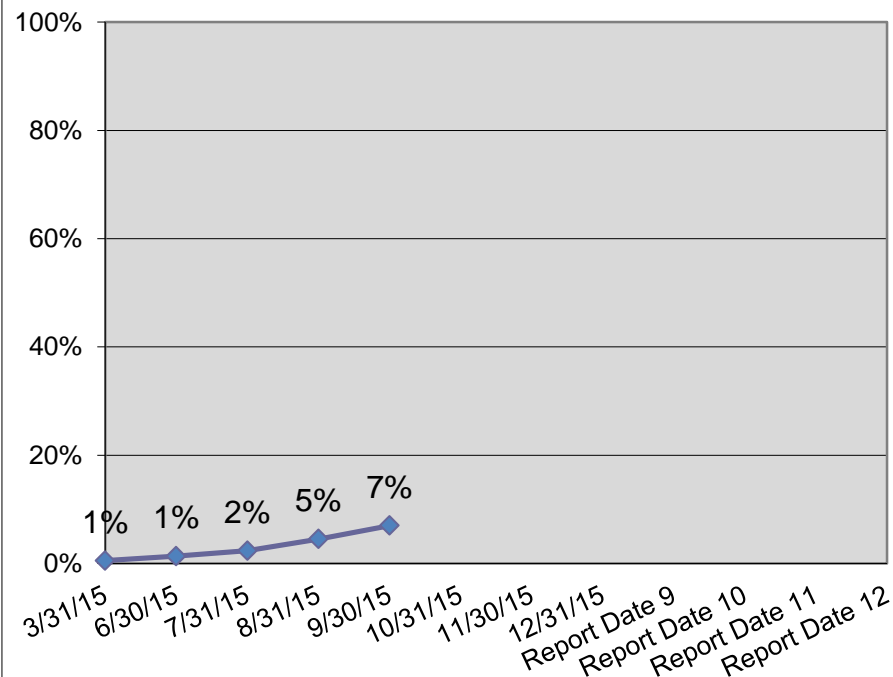
Early Data from SURHC

Pediatric Well Visits

Percent of visit for patients in target population in which oral health screening was done

Data points: 4%, 5%, 11%, 24%, 30% across Report Date 1 through Report Date 5
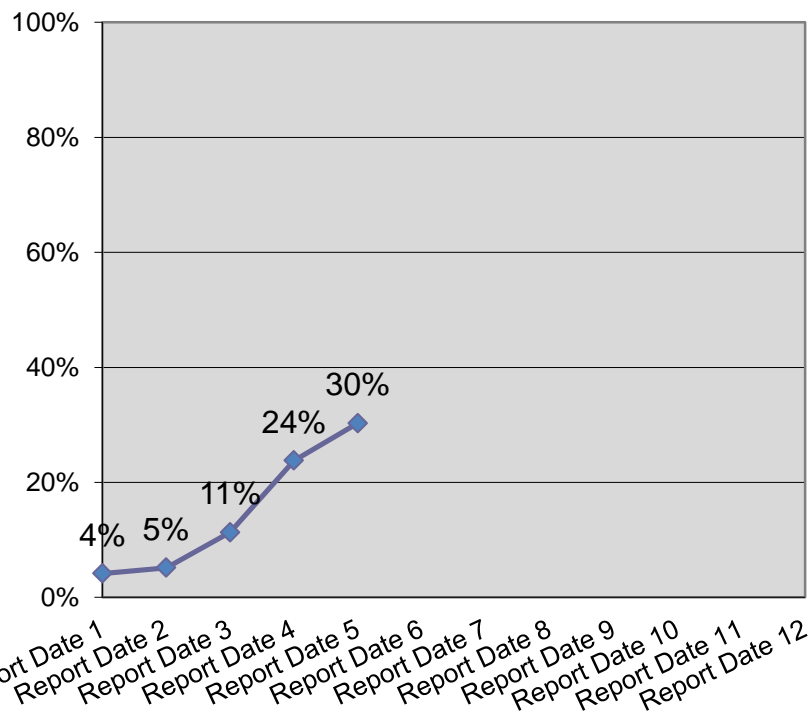
Adult Well Visits

Percent of visits for patients in target population in which oral health screening was done

Data points: 1%, 1%, 2%, 5%, 7% across 3/31/15, 6/30/15, 7/31/15, 8/31/15, 9/30/15

Early Data from SURHC

- Adult Findings:
  - 34% of had signs of caries
  - 22% had signs of periodontal disease
  - Interventions
    - fluoride varnish
    - referral to dentistry

- Pediatric Findings:
  - More variation in the pediatric population
  - Interventions
    - fluoride varnish
    - oral health education handouts
    - fluoride toothpaste and a toothbrush
    - referral to dentistry

Lessons Learned: Recruitment

- Vision of "whole person care" is a must
  - Essential role of clinical champion with committed care team
  - Support of leadership is key
  - Value of learning population health skills for value-based reimbursement
- Set expectations lower rather than too high
  - Avoid overwhelming practice
  - Simply opening the door is a success
  - EHR changes often daunting

Lessons Learned: Recruitment

"Goldilocks and the Three Bears"

- <u>Too small</u>: inadequate resources
  - EHR lack reporting capability
  - Teams often small

- <u>Too big</u>: Multi-specialty delivery systems
  - Priorities inflexible and decided well into future
  - EHR locked down for standardization

- <u>Just right</u>: multiple sites - innovative leaders
  - Agile and able to make decisions
  - Ability to control EHR reporting

Lessons Learned: Technical Assistance

Health IT is a major challenge

- Although most EHRs can create new data entry fields for structure data, it is not easy

- Reporting requires special tools and special expertise

- We've had success working with EHR service provider, and spreading within their client base (Centricity, Epic)

Lessons Learned: Referral Network

Four kinds of patients

1. Already has a dentist

2. Has job-related dental insurance; no dentist

3. Has Medicaid; no dentist

4. No dental "insurance"; no dentist

Referral Network: A plan for each

1. Referral agreement with dentist

2. Dentist willing to to take new patients

3. CHC willing to take new patients

4. Location willing to accept sliding scale

Lessons Learned: Referral Network

- Referral network is challenging
  - Clinicians often don't know dentists
  - Many dentists are not looking for patients
- Network Building Strategies
  - CHCs growing dental practices on Medicaid
  - Bundling: Dentists with empty chairs often welcome mixed insurance stream of patients
  - Person relationships are valuable
- Information exchange is often primitive

Lessons Learned: Staying on Track

Regular check in with practice is essential: otherwise it gets lost

- Tasks from workflow optimization
- EHR modification
- Running & modifying the pilot
- Reporting process outcomes
- Spread

Lessons Learned: Workflow

- Most practices don't need "redesign"
- Streamlined process improvement: more visual; more interactive with technology
- "Minimalism" rather than "over-build"
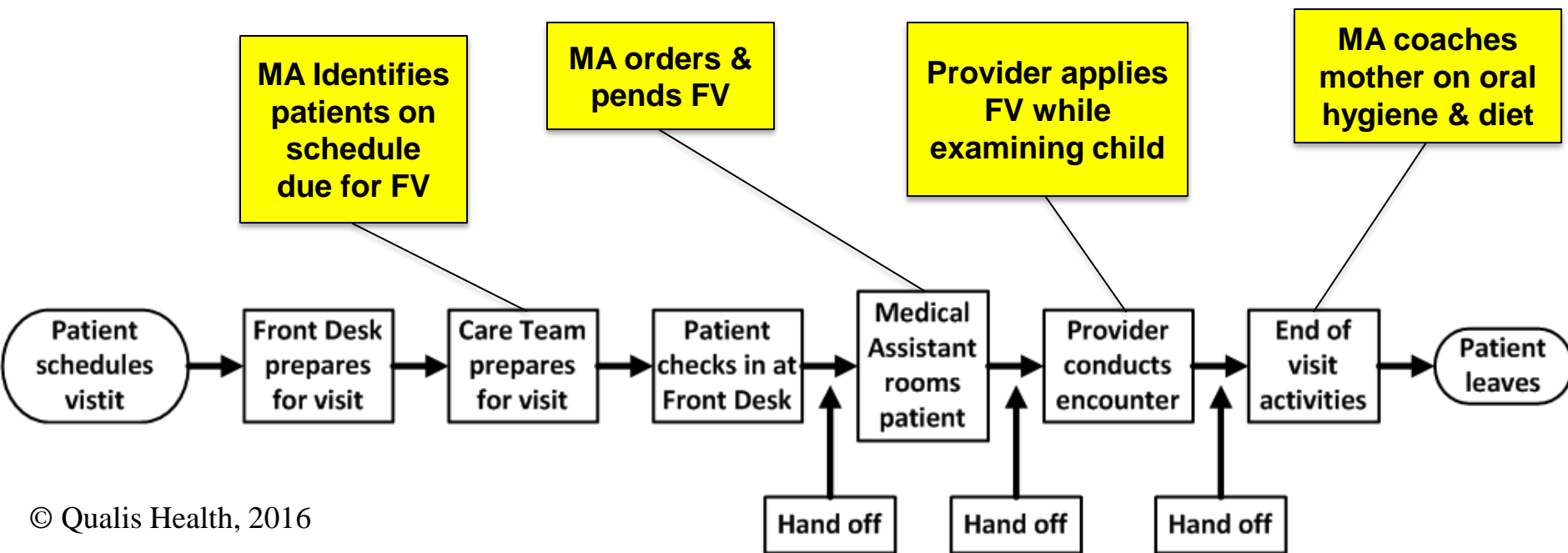
What motivates primary care teams to engage in oral health?

- Awareness of disease burden

- Growing recognition that poor oral health compromises *overall* health:

  – New evidence demonstrating a relationship between periodontal disease & diabetes, ischemic vascular disease, pre-term delivery and low-birth weight

- Intervention only takes a few minutes, and it makes a difference

"This is the right thing to do for my patients."

There are challenges…

- Competing priorities & change fatigue: Behavioral health integration, value-based reimbursement, ICD-10, other chronic disease care

- Behavior change is difficult; limited time for dietary counseling and oral hygiene training in a 15-min visit
  - Distill to core messages
  - Successful practices think creatively about *who* can help: AmeriCorps Volunteer, WIC Specialist, Community Health Workers, waiting room video

Opportunity to Achieve Triple Aim

- Strong evidence that integrated behavioral health care produces better outcomes at lower costs; patients value integrated care

- Expect the same for integrated oral health care

Support From

National *Interprofessional Initiative* on Oral Health
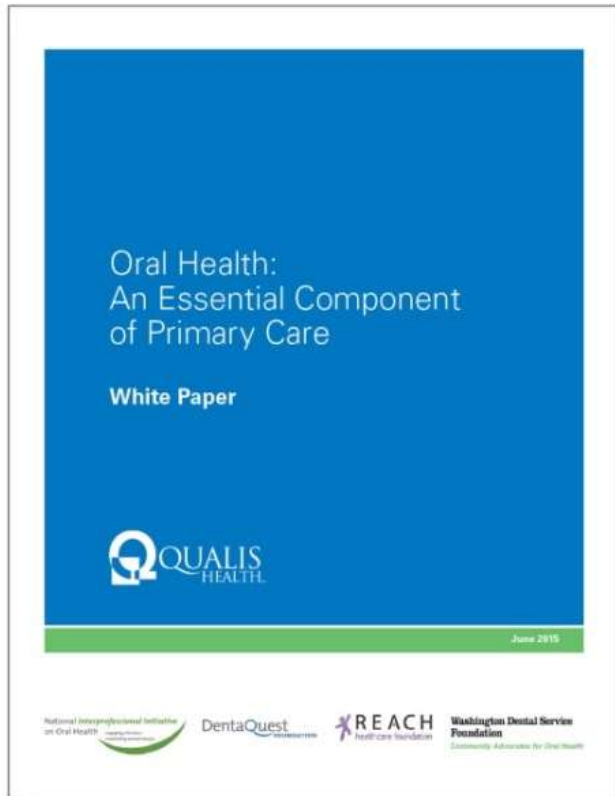*engaging clinitians, eradicating dental disease*

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Washington Dental Service Foundation
Community Advocates for Oral Health

Learn More

Oral Health:
An Essential Component
of Primary Care

White Paper

Resources available at:
www.QualisHealth.org/white-paper

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